

Case

Ordinary Negligence or Medical Malpractice?

Catherine Hemming was a resident at Oak Woods Nursing Center. She suffered from dementia and diabetes, had suffered several strokes, and required 24-hour care that included assistance with grooming, eating, toileting, and bathing. The patient's condition impaired her judgment and reasoning ability and, in turn, caused cerebral atrophy (loss of brain cells). Ms. Hemming had no control over her movements in bed, and hence, was prone to sliding about without sensing her position in bed. This lack of control was addressed in the patient's plan of care in which the facility's medical director authorized the use of various physical restraints. These included bed rails to keep the patient from sliding out of the bed, and a restraining vest that would keep her from moving her arms, thereby impeding her ability to slide. The physician's orders also included wedges or bumper pads that were placed on the outer edge of the mattress to keep the patient from hurting herself by striking, or by entangling herself in the rails. According to nursing home regulations, the use of restraints of this sort must be authorized by a physician to prevent overuse and excessive patient confinement.

Ms. Hemming died of asphyxiation after her neck got caught between the raised bed rails and the mattress. The day before her death, two nursing assistants had found the patient tangled in her restraining vest, gown, and bed sheets. The employees untangled her, repositioned her, and used wedges and pads so that she would not slide into the gap between the mattress and the bed rail. Whether the aides informed their supervisor about the risk remained unclear.

Denise Benton, as personal representative of Hemming's estate, sued Oak Woods. After subsequent amendments to the initial complaint, the case eventually came before the state's Supreme Court. In claiming medical malpractice, Benton's complaint made four specific allegations: (i) Oak Woods failed to ensure that Ms. Hemming was provided an accident-free environment; (ii) Oak Woods failed to train its staff to assess the dangers posed by bed rails and the risk of potential asphyxiation; (iii) Oak Woods failed to inspect the beds, bed frames, and mattress to ensure that the risk of positional asphyxia did not exist; and (iv) Oak Woods failed to take adequate corrective measures and protect Ms. Hemming after she had been found entangled in her bedding on the day before her death from asphyxiation. The complaint alleged that the facility had notice of the risk of asphyxiation through the nursing assistants, but despite this knowledge of the problem did nothing to rectify it.

Notes: 1. There are different types of bed rails that can be prescribed based on a patient's medical history and behavior. 2. This is a real court case that was initially brought before a county circuit court. All names have been disguised.

for Review

ligence

patients
y

ages
superior

torship
v
tgment

ibility

ther Thought

embedded in
) What do you
damages in this

what basis did
Smith? (b) Who
pective of both